

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03100

Reg. Dist. No.

3129

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster RD #6</u>		c. LENGTH OF STAY in lb <u>6 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster RD #6</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bird Hill</u>				d. STREET ADDRESS <u>Bird Hill</u>			
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>EVA</u> Last <u>ANDREWS</u>				4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Feb. 21, 1886</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>John L. Shapley</u>			
14. MOTHER'S MAIDEN NAME <u>Marian Cook</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Wallace E. Andrews</u> Address <u>Westminster RD #6</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary insufficiency</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James T. Marsh</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>3/16/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Rural Westminster, Md.</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminster Md.</u>				ADDRESS <u>—</u>			
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Krawe</u>		DATE <u>MAR 21 '60</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3128

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. OCCUPATION		8. MARITAL STATUS		9. EDUCATION		10. RELIGION		11. SOCIAL SECURITY NUMBER		12. DATE OF DEATH	
13. PLACE OF DEATH		14. TIME OF DEATH		15. CAUSE OF DEATH		16. MANNER OF DEATH		17. SIGNATURE OF EXAMINER		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN		21. SIGNATURE OF CLERK		22. SIGNATURE OF JUDGE		23. SIGNATURE OF PROSECUTOR		24. SIGNATURE OF DEFENSE	
25. SIGNATURE OF CORONER		26. SIGNATURE OF JURY		27. SIGNATURE OF JUDGE		28. SIGNATURE OF PROSECUTOR		29. SIGNATURE OF DEFENSE		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF NEXT OF KIN		33. SIGNATURE OF CLERK		34. SIGNATURE OF JUDGE		35. SIGNATURE OF PROSECUTOR		36. SIGNATURE OF DEFENSE	
37. SIGNATURE OF CORONER		38. SIGNATURE OF JURY		39. SIGNATURE OF JUDGE		40. SIGNATURE OF PROSECUTOR		41. SIGNATURE OF DEFENSE		42. SIGNATURE OF WITNESS	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF NEXT OF KIN		45. SIGNATURE OF CLERK		46. SIGNATURE OF JUDGE		47. SIGNATURE OF PROSECUTOR		48. SIGNATURE OF DEFENSE	
49. SIGNATURE OF CORONER		50. SIGNATURE OF JURY		51. SIGNATURE OF JUDGE		52. SIGNATURE OF PROSECUTOR		53. SIGNATURE OF DEFENSE		54. SIGNATURE OF WITNESS	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF NEXT OF KIN		57. SIGNATURE OF CLERK		58. SIGNATURE OF JUDGE		59. SIGNATURE OF PROSECUTOR		60. SIGNATURE OF DEFENSE	
61. SIGNATURE OF CORONER		62. SIGNATURE OF JURY		63. SIGNATURE OF JUDGE		64. SIGNATURE OF PROSECUTOR		65. SIGNATURE OF DEFENSE		66. SIGNATURE OF WITNESS	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF NEXT OF KIN		69. SIGNATURE OF CLERK		70. SIGNATURE OF JUDGE		71. SIGNATURE OF PROSECUTOR		72. SIGNATURE OF DEFENSE	
73. SIGNATURE OF CORONER		74. SIGNATURE OF JURY		75. SIGNATURE OF JUDGE		76. SIGNATURE OF PROSECUTOR		77. SIGNATURE OF DEFENSE		78. SIGNATURE OF WITNESS	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF NEXT OF KIN		81. SIGNATURE OF CLERK		82. SIGNATURE OF JUDGE		83. SIGNATURE OF PROSECUTOR		84. SIGNATURE OF DEFENSE	
85. SIGNATURE OF CORONER		86. SIGNATURE OF JURY		87. SIGNATURE OF JUDGE		88. SIGNATURE OF PROSECUTOR		89. SIGNATURE OF DEFENSE		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF NEXT OF KIN		93. SIGNATURE OF CLERK		94. SIGNATURE OF JUDGE		95. SIGNATURE OF PROSECUTOR		96. SIGNATURE OF DEFENSE	
97. SIGNATURE OF CORONER		98. SIGNATURE OF JURY		99. SIGNATURE OF JUDGE		100. SIGNATURE OF PROSECUTOR		101. SIGNATURE OF DEFENSE		102. SIGNATURE OF WITNESS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03101

3130

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Sykesville		c. LENGTH OF STAY IN 1b 58 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-- Sykesville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Liberty Rd.				d. STREET ADDRESS Liberty Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH COLUMBUS BARNES First Middle Last				4. DATE OF DEATH Month MARCH Day 26 Year 19 60			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-28-1878	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer				10b. KIND OF BUSINESS OR INDUSTRY owner		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George W. Barnes				14. MOTHER'S MAIDEN NAME Martha Bowers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ----		17. INFORMANT Mrs. Custus Barnes, Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma prostate, metastatic to DUE TO bone, attention to bladder & rectum - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) Arteriosclerosis DUE TO (c) Arteriosclerosis, bronchial pneumonia						INTERVAL BETWEEN ONSET AND DEATH 1956 to 26 Mar 60	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1916 19 to 26 Mar 19 60 , that (I) (we) last saw the deceased alive on 26 Mar 19 60 , and that death occurred at 1:15 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Howard E. Hall				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) HOWARD E. HALL				22d. ADDRESS SYKESVILLE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-28-1960		23c. NAME OF CEMETERY OR CREMATORY Messiah Lutheran		23d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Md.				25a. REC'D BY REGISTRAR DATE MAR 29 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

BP 1

CERTIFICATE OF DEATH

3130

Cattell

Maryland

Cattell

Liberty Road

28 yrs.

Liberty Rd.

82

2-28-1900

white

male

U.S.

Maryland

Switzer

retired farmer

Martin Powers

George W. Barnes

same

Mrs. Charles Barnes

no

Maryland

Sylvester

Howard E. Hall

Maryland

Cattell Co.

Messiah Lutheran

Born 2-28-1900

Wintfield, Md.

C. M. Wolfe

3131

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Seabrook</i>	c. LENGTH OF STAY IN 1b <i>2 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Seabrook</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>ROBERT E BECKNER</i>		4. DATE OF DEATH Month <i>Mar</i> Day <i>31</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 12 1890</i>
9. AGE (In years last birthday) <i>69</i> yrs.		IF UNDER 1 YEAR Months <i>6</i> Days <i>9</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>F. Beckner</i>	
14. MOTHER'S MAIDEN NAME <i>Rosemary R. Beckner</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>210-30-0469</i>		17. INFORMANT <i>Mr. Robert E. Beckner, Seabrook, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anterograde Renal Disease</i> <i>446X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>April</i> , 1949, to <i>March 31</i> , 1960, that I last saw the deceased alive on <i>March 31</i> , 1960, and that death occurred at <i>11:30 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W.H. Foard</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>Manchester, Md. 4/1/60</i>	
PHYSICIAN'S NAME (Type) <i>W.H. Foard MD</i>		<i>Manchester, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>Apr 4 1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Black Rock Church</i>	22d. LOCATION (City, town, or county) (State) <i>Seabrook P.O. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kraus</i>		ADDRESS <i>5th St. N.E., So</i>	
24a. REC'D BY REGISTRAR DATE <i>APR 4 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 2 3
3132
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
03103

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berrett</u>		c. LENGTH OF STAY IN 1b <u>Rife</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berrett</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Sylville P.O.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CARRIE HEWITT BENNETT</u>				4. DATE OF DEATH <u>March 2, 1960</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 5, 1876</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David M. Shoemaker</u>				14. MOTHER'S MAIDEN NAME <u>Mary S. Black</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>M. John W. Shoemaker</u> Address <u>Sylville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, Coronary thrombosis,</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis generalized, cerebral</u> DUE TO (c) <u>pneumonia.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1556</u> <u>70</u> <u>3-2-60</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , 19 <u>56</u> , to <u>2 March</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>2 March</u> 19 <u>60</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard E. Hall</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>				22d. ADDRESS <u>Sylville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3-5-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Messiah Lutheran</u>		23d. LOCATION (City, town, or county) (State) <u>Berrett, Carroll Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u> ADDRESS <u>Sylville, Md.</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	
DATE <u>MAR 8 '60</u>							

05103

RECEIVED AT 12:00 PM

RECEIVED AT 12:00 PM

CENTRAL OFFICE

0135

1

3126

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL CO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER MD.		c. LENGTH OF STAY IN 1b 7 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY ELLEN BOLLINGER		4. DATE OF DEATH Month 3 / Day 17 / Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 9. 1978
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH WANTZ		14. MOTHER'S MAIDEN NAME CATHERINE ROSER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 217-28-6308	
17. INFORMANT —		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis (chr) Hypertension (acute) 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) "Flu" Asthma, pleurisy, DUE TO (c) Hypertension.			INTERVAL BETWEEN ONSET AND DEATH —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. — 19 —		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from Jan 19 40 to Mar 17 1960 , that I last saw the deceased alive on Mar 17 1960 , and that death occurred at 8:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 103 E Main Westminster Md DATE SIGNED 3-18-60			
ACTUAL SIGNATURE Wm C. Jannetta		M.D. 103 E Main Westminster Md	
PHYSICIAN'S NAME (Type) Wm C. Jannetta		103 E Main Westminster Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/20/60	22c. NAME OF CEMETERY OR CREMATORY KRIDE-RS CEM.	22d. LOCATION (City, town, or county) (State) WESTMINSTER MD.
23. FUNERAL DIRECTOR'S SIGNATURE James G. Saffell		ADDRESS Westminster, Md	
24a. REC'D BY REGISTRAR MAR 21 60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3130

NAME OF DECEASED *WILLIAM WATTS*

DATE OF DEATH *2/11/1917*

PLACE WHERE DECEASED *WATTS*

AGE *31*

WATTS

WATTS

WATTS

WATTS

WATTS

WATTS

WATTS

WATTS

WATTS

WATTS

FOR STATE
HEALTH DEPT.

TO THE COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
3133 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 4 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			1556-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield Hospital					d. STREET ADDRESS 12226 Selfridge Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LLOYD W. BOWERS					4. DATE OF DEATH Month March Day 7 Year 19 60				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/18/94		9. AGE (In years last birthday) 65 yrs.	
						IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LORENZA WILLIAM BOWERS					14. MOTHER'S MAIDEN NAME ELIZABETH BELL SMITH				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 578-10-0638		17. INFORMANT Address Mrs. Mary C. Bowers, 12,718 Gould Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Confluent Bronchopneumonia, Bilateral. 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) } (c) DUE TO (e), stating the underlying cause last. (c) } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subdural Hematoma, and Purulent Meningitis									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from ladder					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12/11 19 59 p.m.			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown		20f. (City or town) (County) (State) Unknown		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/8/60 ACTUAL SIGNATURE Charles S. Petty M.D. EXAMINER'S NAME (Type) Charles S. Petty, M.D. Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/11/60		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY			22d. LOCATION (City, town, or country) (State) MONTGOMERY COUNTY, MARYLAND		
23. FUNERAL DIRECTOR WARNER E. PUMPHREY, INC. Raymond W. Ziska					ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR MAR 11 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kneal

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

3134

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03106

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1 yr. 4 mos. 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 2030 Jefferson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Francine Middle Edna Last Bright				4. DATE OF DEATH Month March Day 25 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 24, 1889	
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min.		IF UNDER 24 HRS. Months 70 Days 70 Hours 70 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edward S. Bright				14. MOTHER'S MAIDEN NAME Anjeannette Holidayoke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) C.B.S. assoc. with cerebral arteriosclerosis with neurotic reaction.				INTERVAL BETWEEN ONSET AND DEATH Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with neurotic reaction.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from October 29, 1958 to March 25, 1960 , that (I) (we) last saw the deceased alive on 3/24/60 19, and that death occurred at 5:40 AM from the causes and on the date stated above.							
22a. SIGNATURE Edmund Lusthaus				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/25/60	
22c. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 21/60		23c. NAME OF CEMETERY OR CREMATORY St. Ann's Cem.		23d. LOCATION (City, town, or county) (State) Annapolis Md	
24. FUNERAL DIRECTOR'S SIGNATURE Philip Herwigsons				ADDRESS 2024 Orleans St		25a. REC'D BY REGISTRAR MAR 28 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

CERTIFICATE OF DEATH

8134

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CITY OF BOSTON
COUNTY OF SUFFOLK

DECEASED: JOHN J. BROWN
DATE OF DEATH: 1912
PLACE OF DEATH: HOME
AGE: 65
SEX: MALE
RACE: WHITE
BIRTH: 1847
MARRIAGE: 1870
OCCUPATION: LABORER
CAUSE OF DEATH: HEART DISEASE
SIGNATURE: [Signature]
DATE: 1912

1
 3135
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 03107

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Sykesville				c. LENGTH OF STAY IN 1b 2 mo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkins 75x3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 090 Golden Age Quest Home				d. STREET ADDRESS Sykesville PA		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. NAME OF DECEASED (Type or print) LOUIS First M. Middle CARGILL Last				4. DATE OF DEATH 3 Month 29 Day 1960 Year			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-20-1868	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired contractor		10b. KIND OF BUSINESS OR INDUSTRY building		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Cargill				14. MOTHER'S MAIDEN NAME Ella Reynolds			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ida Weber, Ellicott City, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Genl Arterio Sclerosis DUE TO ✓ Hypertension (c) ✓						INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ✓						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ✓					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar 16 19 60 to Mar 28 19 60 that (I) (we) last saw the deceased alive on 19 and that death occurred at 1P M, from the causes and on the date stated above.							
22a. SIGNATURE Harrell H. Martin				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-29-60	
22c. PHYSICIAN'S NAME (Type) MARTIN MD				22d. ADDRESS Sykesville Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-1-1960		23c. NAME OF CEMETERY OR CREMATORY Ebenezer		23d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Maryland		25a. REC'D BY REGISTRAR DATE APR 4 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kenna			

3132

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

Mr. I. J. Kervill

Age

Sex

White

Male

10-20-1908

1

Resided at

Building

Alameda

U.S.

George Kervill

Alie Reynolds

Mr. J. H. Weber, Milwaukee City, Wis.

no

CHIEF CLERK

Mr. I. J. Kervill

Age

George Kervill

White

Male

10-20-1908

3-20-60

CERTIFICATE OF DEATH

Reg. Dist. No.

03108

3135

1. PLACE OF DEATH a. COUNTY CARROLL COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION MILLS MD.		c. LENGTH OF STAY IN 1b 1 YR.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEADOW VIEW CONVALESCENT HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK VACLAV CECH		4. DATE OF DEATH Month Day Year 3 / 26 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 25, 1869
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10b. KIND OF BUSINESS OR INDUSTRY GARMENT	
11. BIRTHPLACE (State or foreign country) CZECHOSLOVAKIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME VACLAV CECH		14. MOTHER'S MAIDEN NAME JOSEFA HAKOVA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 212-12-1485	
17. INFORMANT Address SON FRANK CECH JR. WESTMINSTER MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cystitis; Paralysis of left side due to cerebrovascular 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 5 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) occlusion	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 10, 1958 to Mar. 26, 1960 , that I last saw the deceased alive on Mar 26, 1960 , and that death occurred at 10A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Julius Chepko		ADDRESS (Street, city or town, state) 85 1/2 W Green St Westminister, Md	
PHYSICIAN'S NAME (Type) Julius Chepko		DATE SIGNED 3/27/60	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/30/60	
22c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER		22d. LOCATION (City, town, or county) (State) BALTO- MD.	
23. FUNERAL DIRECTOR'S SIGNATURE James G. Saffell Jr. Westminister, Md		24a. REC'D BY REGISTRAR MAR 29 '60	
ADDRESS Westminister, Md		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be joined by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and destroy the papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
COUNTY OF ...
IN SENATE
JANUARY 1, 1910
REPORT OF THE
COMMISSIONERS OF THE
LAND OFFICE
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE
MAY 1, 1909
RELATIVE TO THE
LANDS BELONGING TO
THE STATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03109

Reg. Dist. No.

3137

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminister, Md 21086</u> c. LENGTH OF STAY IN 1b <u>2 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll County Home</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminister</u> d. STREET ADDRESS <u>Not known</u>													
3. NAME OF DECEASED (Type or print) <u>ALLEN GEORGE DORSEY</u> First Middle Last				4. DATE OF DEATH <u>March 3 1960</u> Month Day Year													
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 17, 1880</u> yrs.		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Railroad Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fred. Co. Md</u>				11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Not known</u>						14. MOTHER'S MAIDEN NAME <u>Not known</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. <u>216-14-5628</u>				17. INFORMANT <u>Carroll County Home Records, Westminister, Md</u> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A.S.C.V. disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>James T. Marshall</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>3-3-60</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/7/60</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Carroll Co. Home Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Rural Westminister, Md</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u> ADDRESS <u>Westminister, Md</u>						24a. REC'D BY REGISTRAR <u>Arthur S. Hanes</u>						24b. REGISTRAR'S SIGNATURE					
DATE <u>MAR 7 '60</u>						24c. REGISTRAR'S SIGNATURE											

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute and forward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

COUNTY OF BALTIMORE CITY OF BALTIMORE		DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS	
NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		RACE <input type="checkbox"/> WHITE <input type="checkbox"/> NEGRO <input type="checkbox"/> OTHER	
OCCUPATION _____		MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOW <input type="checkbox"/> DIVORCED	
CAUSE OF DEATH _____		MANNER OF DEATH <input type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENTAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE	
TIME OF DEATH _____		PLACE OF DEATH _____	
SIGNATURE OF MEDICAL EXAMINER _____		SIGNATURE OF REGISTRAR _____	
DATE OF EXAMINATION _____		DATE OF REGISTRATION _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completed certificate filed in by the funeral director. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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3138

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

C3110

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 37 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS SPRINGFIELD STATE HOSP. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice M. Garvey Gardiner		4. DATE OF DEATH Month March Day 12 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/13/79
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Peter Garvey		14. MOTHER'S MAIDEN NAME Mary Hogan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Daughter: Mrs. James Richards		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 904.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture of Pubis DUE TO (c) Schizophrenic reaction, hebephrenic type	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, hebephrenic type			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fell down		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 6 p. m. 2/19 1960		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) (County) (State) Sykesville Carroll Maryland	
21. I certify that (I) (this hospital) attended the deceased from 2/23/1960 to 3/12/1960 , that (I) (we) last saw the deceased alive on 3/12/1960 , and that death occurred at 12 M from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo M.D.		22b. ADDRESS Sykesville Maryland	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Sykesville Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/15/60	
23c. NAME OF CEMETERY OR CREMATORY CATHEDRAL CEMETERY		23d. LOCATION (City, town, or county) (State) BALTO.	
24. FUNERAL DIRECTOR'S SIGNATURE WIEDEFELD & SON-GREENMOUNT AVE & 22ND		25a. REC'D BY REGISTRAR DATE MAR 16 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna		25c. DATE MAR 16 '60	

UNITED STATES OF AMERICA

3133



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be obtained by the hospital attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03111

3139

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD - Rural.</u>		c. LENGTH OF STAY IN 1b <u>8 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Baltimore Pike</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Samuel P.</u> Last <u>Giggard</u>		4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14, 1891</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Laborer.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>General.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ADAM Giggard.</u>	
14. MOTHER'S MAIDEN NAME <u>LIZZIE ANN Mathias</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>189-07-2698</u>		17. INFORMANT Address <u>SUSAN Croft. HAMPSTEAD Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-Sclerotic Cardio Vascular Disease</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/21</u> , 1960, to <u>3-25</u> , 1960, that I last saw the deceased alive on <u>3/25</u> , 1960, and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Maryland</u>	
DATE SIGNED <u>3/25/60</u>			
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush, M.D.</u>		<u>HAMPSTEAD Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-27-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Peter</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw C. Tipton - Hampstead Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>MAR 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03112

3140

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Virginia b. COUNTY Boonesville	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 1		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First MARK Middle Hann Last GOINS		4. DATE OF DEATH Month March Day 21 Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 1904
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 56	IF UNDER 24 HRS. Hours 56 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Sawmill	
11. BIRTHPLACE (State or foreign country) Boonesville Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Alfred Goins		14. MOTHER'S MAIDEN NAME Ida	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT J.F. Bell		Address 108-6th St. N.W. Charlottesville Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Arteriosclerotic Heart Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Partially		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/22/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Shipped		22b. DATE THEREOF March 23/60	
22c. NAME OF CEMETERY OR CREMATORY Browns Cove Cem.		22d. LOCATION (City, town, or county) (State) Charlottesville Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Katie R. Williams		ADDRESS 322 N. Schroeder St.	
24a. REC'D BY REGISTRAR MAR 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. K...	

3127

CERTIFICATE OF DEATH

03113

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. LENGTH OF STAY IN 1b <u>62</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>258 E. Green St.</u>				d. STREET ADDRESS <u>258 E. Green St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MERRITT EUGENE GROFT</u>				4. DATE OF DEATH Month Day Year <u>MARCH 4 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 8 1897</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>State Road employee (Laborer)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Ind</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph Groft</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Otto</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Mr. Helen Bowes Drift, Westminster, Md</u>		Address <u>Penna.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Disease of Coronary Arteries</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March 1960</u> to <u>Mar. 4, 1960</u> , that I last saw the deceased alive on <u>Mar. 3, 1960</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Westminster, Md.</u> DATE SIGNED <u>5-4-60</u>							
ACTUAL SIGNATURE <u>C. L. B. Illingsea</u> M.D.							
PHYSICIAN'S NAME (Type) <u>C. L. B. Illingsea</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 7, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyer, Jr.</u>				ADDRESS <u>Westminster, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 7 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3123

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>		4. DATE OF BIRTH <i>1910-10-15</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Retired</i>	
7. MARITAL STATUS <i>Married</i>		8. RACE <i>White</i>		9. RELIGION <i>Catholic</i>		10. EDUCATION <i>High School</i>		11. SOCIAL SECURITY NUMBER <i>1-234-567890</i>		12. DATE OF DEATH <i>1975-11-10</i>	
13. PLACE OF DEATH <i>Home</i>		14. CAUSE OF DEATH <i>Heart Disease</i>		15. MANNER OF DEATH <i>Natural</i>		16. PERIOD OF ILLNESS <i>2 weeks</i>		17. PREVIOUS ILLNESS <i>None</i>		18. SIGNATURE OF PHYSICIAN <i>Dr. J. K. L.</i>	
19. SIGNATURE OF DECEASED <i>John J. Smith</i>		20. SIGNATURE OF NEXT OF KIN <i>John J. Smith</i>		21. SIGNATURE OF WITNESSES <i>John J. Smith</i>		22. SIGNATURE OF CLERK <i>John J. Smith</i>		23. SIGNATURE OF REGISTRAR <i>John J. Smith</i>		24. SIGNATURE OF JUDGE <i>John J. Smith</i>	

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE PHYSICIAN, NEXT OF KIN, WITNESSES, CLERK, REGISTRAR, AND JUDGE. IT IS VOID IF ANY OF THESE SIGNATURES ARE MISSING OR IF THE SIGNATURES ARE NOT SIGNED IN THE PRESENCE OF THE REGISTRAR AND JUDGE. IT IS VOID IF THE SIGNATURES ARE NOT SIGNED IN THE PRESENCE OF THE REGISTRAR AND JUDGE. IT IS VOID IF THE SIGNATURES ARE NOT SIGNED IN THE PRESENCE OF THE REGISTRAR AND JUDGE.

3128

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>85 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>271 Westminister</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>252 E. Green St.</u>				d. STREET ADDRESS <u>1 252 E. Green St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RUSSELL LEE HAINES</u>				4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 9, 1874</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>nursery</u>		11. BIRTHPLACE (State or foreign country) <u>Westminister Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse L. Haines</u>				14. MOTHER'S MAIDEN NAME <u>Anna ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Chas. L. Haines</u> Address <u>Westminister, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary disease</u> DUE TO (c) <u>arterio sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr + 6 to 7 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1950</u> to <u>Mar 29 1960</u> that I last saw the deceased alive on <u>Mar 26 1960</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Reese Wilkens</u>				ADDRESS (Street, city or town, state) <u>15 Kemper Ave. 36910</u>			
PHYSICIAN'S NAME (Type) <u>E. REESE WILKENS</u>				DATE SIGNED <u>Westminister, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/1/60</u>		<u>Westminister Cemetery</u>		<u>Westminister, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers Jr.</u>				ADDRESS <u>Westminister, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 31 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, the certificate and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

03115

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Mills.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Line</u> 03X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>090 Meadow View Nursing Home.</u>		d. STREET ADDRESS <u>Main St.</u>	
3. NAME OF DECEASED (Type or print) <u>BLANCHE ORRINGTON HENDRIX</u>		4. DATE OF DEATH <u>MARCH 27 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 21 1878</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Daniel Kroh</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wilhelm.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. C.W. Stewart, Maryland Line Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>332 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL THROMBOSIS WITH HEMIPLEGIA</u> DUE TO <u>7 WKS</u> (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO <u>10 YRS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 WKS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>FEB 27, 1960</u> , to <u>MARCH 27, 1960</u> , that I last saw the deceased alive on <u>MARCH 27, 1960</u> , and that death occurred at <u>4:55 PM</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William T. Stewart,</u> M.D.		ADDRESS (Street, city or town, state) <u>19 RIDGE RD.</u> DATE SIGNED <u>3/27/60</u>	
PHYSICIAN'S NAME (Type) <u>William T. Stewart</u>		<u>WESTMINSTER, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>March 30, 1960</u>	<u>Md. Line Cemetery</u>	<u>Md. Line, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Hartenstein, New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>MAR 29 '60</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3125

CERTIFICATE OF DEATH

03116

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		c. LENGTH OF STAY IN 1b 45 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 509 S. Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle D. Last HOOD		4. DATE OF DEATH Month March Day 12 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-21-1885
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired merchant		10b. KIND OF BUSINESS OR INDUSTRY Clothing store	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME David M. Devilbiss		14. MOTHER'S MAIDEN NAME Lizzy M. Clary	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-32-1885	
17. INFORMANT Marshall Hood		Address Easton; 632 Howard St. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive + arteriosclerotic cardiovascular disease DUE TO (c) about 18 years		INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. , 19 51 , to March , 19 60 , that I last saw the deceased alive on Dec. 29 , 19 59 , and that death occurred at 7:50 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. B. Culwell		ADDRESS (Street, city or town, state) 900 So. Main St. Mt. Airy, Md.	
PHYSICIAN'S NAME (Type) W. B. CULWELL		DATE 3/12/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-15-1960	
22c. NAME OF CEMETERY OR CREMATORY Prospect		22d. LOCATION (City, town, or county) (State) Frederick Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR MAR 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

RECEIVED
CENTRAL OFFICE OF RECORDS
JAN 10 1960

Mr. A. J. ...
500 S. Main St.
St. Louis, Mo.

MANAGEMENT
1-11-1960
St. Louis, Mo.

David H. ...
216-32-1885
St. Louis, Mo.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 C Film G260 4/12/60 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

3142

03117

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Sykesville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore d. STREET ADDRESS 218 South Chester Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle ----- Last Horn		4. DATE OF DEATH Month 3 Day 28 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-26-1887
9. AGE (In years last birthday) 73		IF UNDER 1 YEAR Months --- Days --- Hours --- Min. ---	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Horn		14. MOTHER'S MAIDEN NAME Kunigunda Rotherhouse	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Springfield State Hospital Records		Address -----	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Generalized arteriosclerosis (c) Recently leftsided hemiparesis		INTERVAL BETWEEN ONSET AND DEATH 5 min. years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, catatonic type		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -----		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. ---		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from 1953 , to March 28 , 19 60 that I last saw the deceased alive on March 28 , 19 60 , and that death occurred at 5:40 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 3-28-60			
ACTUAL SIGNATURE Myron Nizankowsky		PHYSICIAN'S NAME (Type) Myron Nizankowsky	
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Burial		22b. DATE THEREOF 3/31/60	
22c. NAME OF CEMETERY OR CREMATORY Immanuel Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul A. Heeman		24a. REC'D BY REGISTRAR DATE APR 1 '60	
ADDRESS 6067 Harford Rd.		24b. REGISTRAR'S SIGNATURE Arthur S. Heenan	

3162

STATE OF OHIO

Bellevue, Ohio

January 1, 1900

Ohio

1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03118

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3143

Items 7, 8 & 9 Film G258 3/11/60 lwk

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL CO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MD. b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE				c. LENGTH OF STAY IN 1b 16yr. 1mo. 4d.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRINGFIELD STATE HOSPITAL.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EVA Middle KEMP Last KEMP				4. DATE OF DEATH Month 3 Day 5 Year 19 60			
5. SEX FEMALE		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/11/60 2/11/159	
9. AGE (In years last birthday) 159 yrs.		IF UNDER 1 YEAR Months 3 Days 5 Hours 19 Min.		IF UNDER 24 HRS. Months 3 Days 5 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert Kemp				14. MOTHER'S MAIDEN NAME KATHERINE BUCKS.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. None			
17. INFORMANT Hosp. records, Sykesville, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Insufficiency 353.1 DUE TO Grand Mal Epileptic seizure - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Post encephalitic Parkinsonism PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post encephalitic Parkinsonism							
INTERVAL BETWEEN ONSET AND DEATH min							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James T. Marsh				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES T MARSH				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 8, 1960		22c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight				ADDRESS Cumberland - Md		24a. REC'D BY REGISTRAR MAR 8 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial/cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2d, Film 6258, 3/17/60 lb

CERTIFICATE OF DEATH

03119

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 Years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Grandview Nursing Home				d. STREET ADDRESS 3700 N.Charles Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Howard		Middle Allen		Last Kephart		4. DATE OF DEATH Month March		Day 12	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18, 1862		9. AGE (In years last birthday) 98 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Medera, Pa.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Daniel Kephart				14. MOTHER'S MAIDEN NAME Lavina Shoff					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address John W. Lohr, Elkins, West Virginia					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic hypertensive cardiovascular disease DUE TO (c) advanced senile changes								INTERVAL BETWEEN ONSET AND DEATH many years many years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 March , 19 56 , to 11 March , 19 60 , that I last saw the deceased alive on 11 March , 19 60 , and that death occurred at 3:15A M, from the causes and on the date stated above.									
ACTUAL SIGNATURE Wm. H. Lawson, Jr.				ADDRESS (Street, city or town, state) Liberty Road at Eldersburg		DATE SIGNED 3/12/60			
PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr., M.D.				Sykesville 2, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 14, 1960		22c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery		22d. LOCATION (City, town, or county) (State) Elkins, Randolph Co., W. Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Arthur N. Haight				ADDRESS Sykesville, Md.		24a. REC'D BY REGISTRAR DATE MAR 15 60		24b. REGISTRAR'S SIGNATURE Ernest D. Hume	

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

3145

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03120

1. PLACE OF DEATH a. COUNTY <i>Carroll Co</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ankenyville</i>				c. LENGTH OF STAY IN 1b <i>5 months</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Miller Nursing Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>ANNIE ELIZABETH KRIPE</i>				4. DATE OF DEATH Month Day Year <i>March 31 1960</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 26, 1887</i>	
9. AGE (In years last birthday) <i>72</i> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>			
11. BIRTHPLACE (State or foreign country) <i>Penna.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Charles Davis</i>				14. MOTHER'S MAIDEN NAME <i>Annie Miller</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>				16. SOCIAL SECURITY NO. <i>—</i>			
17. INFORMANT <i>Mrs Catherine E. Stansbury</i>				Address <i>Westminster Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage - bilateral</i> <i>260X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>pneumonia - bacterial</i> (c) <i>diabetes, arteriosclerotic heart disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>1959 to 31 March 60</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>1959 31 March 1960</i>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1959 19</i> to <i>31 March 1960</i> , that (I) (we) lost the deceased alive on <i>31 March 1960</i> , and that death occurred at <i>6:00</i> PM, from the causes and on the date stated above.							
22a. SIGNATURE <i>Howard E. Hall</i>				22b. DATE SIGNED <i>31 March 60</i>			
22c. PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>				22d. ADDRESS <i>Ankenyville, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>April 3/60</i>			
23c. NAME OF CEMETERY OR CREMATORY <i>Bethel Cemetery</i>				23d. LOCATION (City, town, or county) (State) <i>near Blue Ridge Summit, Md.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Meyer, Jr.</i>				25a. REC'D BY REGISTRAR <i>—</i> DATE <i>APR 5 '60</i>			
ADDRESS <i>Westminster, Md.</i>				25b. REGISTRAR'S SIGNATURE <i>—</i>			

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

[Vertical text on the right margin, likely bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove corobol papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3146

03121

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Taneytown		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Taneytown, Md. X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taneytown, Md. R. D. 1			d. STREET ADDRESS Taneytown, Md. R. D. 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Theodore Middle Bertram Last Koontz			4. DATE OF DEATH Month 3 Day 28 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/17/1876	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY His own farm		11. BIRTHPLACE (State or foreign country) Carroll Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Abraham Koontz			14. MOTHER'S MAIDEN NAME Clementine Hahn		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-36-8182		17. INFORMANT Mrs. Theodore B. Koontz, Taneytown, Md. R.D.1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-Vascular Disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 10 hours 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Littlestown, PA.		20g. (County) Carroll Co., Md.		20h. (State) PA.	
21. I certify that (I) (this hospital) attended the deceased from 8-25 19 57 , to 3-28 19 60 , that (I) (we) last saw the deceased alive on 3-28 19 60 , and that death occurred at 6P M, from the causes and on the date stated above.					
22a. SIGNATURE L. R. Potter M.D.		22b. DATE SIGNED 3-29-60		22c. PHYSICIAN'S NAME (Type) L. L. POTTER M.D.	
22d. ADDRESS LITTLESTOWN, PA.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/31/60		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery	
23d. LOCATION (City, town, or county) Silver Run, Carroll Co., Md.		23e. (State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little		ADDRESS Littlestown, Pa.		25a. REC'D BY REGISTRAR DATE MAR 31 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines					

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3147
CERTIFICATE OF DEATH

03122

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES L. LOWERY		4. DATE OF DEATH Month March Day 12 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/11/1898
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 10 Days 1 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME George D. Lowery	
14. MOTHER'S MAIDEN NAME Annie V. McCrossin		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mary K. Lowery-wife-same as 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1, 1959 to April 12, 1960 that I last saw the deceased alive on April 12, 1960 and that death occurred at 11 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Union Bridge, Md. DATE SIGNED April 12, 1960			
ACTUAL SIGNATURE J. H. Messler M.D.		PHYSICIAN'S NAME (Type) J. H. Messler, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/16/60	22c. NAME OF CEMETERY OR CREMATORY Darnestown Church Cem	22d. LOCATION (City, town, or county) (State) Darnestown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	24a. REC'D BY REGISTRAR DATE MAR 16 '60
24b. REGISTRAR'S SIGNATURE Charles L. Howard			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES J. HANCOCK		MALE		45		JANUARY 1, 1880	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
100 N. BOSTON ST.		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH		TEMPERATURE	
JANUARY 10, 1925		BOSTON		10:00 AM		98.6	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
J. H. HANCOCK		J. H. HANCOCK		J. H. HANCOCK		J. H. HANCOCK	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JANUARY 10, 1925		JANUARY 10, 1925		JANUARY 10, 1925		JANUARY 10, 1925	

BOSTON

J. H. HANCOCK, JR.

Union Bridge, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

3148
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03123

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 mo. 15 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		11X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS Route 2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Amos Middle C. Last Martin		4. DATE OF DEATH Month March Day 10 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1886 Unknown
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done, or if retired) Retired Farmer Unknown		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Peter F. Martin		14. MOTHER'S MAIDEN NAME Unknown Eliza Fike	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no Unknown		16. SOCIAL SECURITY NO. 216-38-1501	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis obliterans DUE TO (c) Bronchopneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction			
INTERVAL BETWEEN ONSET AND DEATH Days Years Days			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 25, 1960 to March 10, 1960 that (I) (we) last saw the deceased alive on March 10, 1960 and that death occurred at 10:25 PM from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo		22b. DATE SIGNED 3/11/60	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/13/1960	
23c. NAME OF CEMETERY OR CREMATORY Red House Cemetery		23d. LOCATION (City, town, or county) (State) Garrett County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Cheighton Oakland Md.		25a. REC'D BY REGISTRAR DATE MAR 14 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3149 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03124

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>12yrs. 3mos. 1day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u> 01X-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>15 Washington St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary</u> <u>McGee</u>				4. DATE OF DEATH Month Day Year <u>March</u> <u>11</u> <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Unknown</u>			
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>James McGee</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Springfield Hospital Records.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>526X</u> DUE TO <u>BRONCHIECTASIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>days</u> DUE TO (c) <u>years</u> </div> <div style="width: 65%;"> INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mental deficiency without psychosis, imbecility.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James T. Marsh</u>				DATE SIGNED <u>3/11/60</u>			
EXAMINER'S NAME (Type) <u>James T. Marsh, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-15-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lonaconing</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. Gilhorn - Lonaconing, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kenna</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing this word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the County Health Officer. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF DEATH _____	
PLACE OF DEATH _____		COUNTY _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		POST-MORTEM EXAMINATION _____	
SIGNATURE OF EXAMINER _____		SIGNATURE OF WITNESS _____	
DATE OF EXAMINATION _____		TIME OF EXAMINATION _____	
PLACE OF EXAMINATION _____		COUNTY OF EXAMINATION _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF NEXT OF KIN _____	
SIGNATURE OF SURVIVOR _____		SIGNATURE OF BURIAL OFFICIAL _____	
SIGNATURE OF MINISTER OF THE GOSPEL _____		SIGNATURE OF CLERGYMAN _____	
SIGNATURE OF CHURCH OFFICER _____		SIGNATURE OF FUNERAL HOME _____	
SIGNATURE OF CEMETERY OFFICER _____		SIGNATURE OF BURIAL OFFICIAL _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF NEXT OF KIN _____	
SIGNATURE OF SURVIVOR _____		SIGNATURE OF BURIAL OFFICIAL _____	
SIGNATURE OF MINISTER OF THE GOSPEL _____		SIGNATURE OF CLERGYMAN _____	
SIGNATURE OF CHURCH OFFICER _____		SIGNATURE OF FUNERAL HOME _____	
SIGNATURE OF CEMETERY OFFICER _____		SIGNATURE OF BURIAL OFFICIAL _____	

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3150

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03125

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 25 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frederick Middle William Last Myers		4. DATE OF DEATH Month March Day 21 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 9, 1903
9. AGE (In years lost birthday) 57 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 57 Days 21 Hours 19 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Myers		14. MOTHER'S MAIDEN NAME Katherine Schiller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War II		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with alcoholism, with psychotic reaction.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from February 26, 1960 to March 21, 1960 that I last saw the deceased alive on March 20, 1960 , and that death occurred at 7:07 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Julian Radcykowycz		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 3/21/60	
PHYSICIAN'S NAME (Type) Julian Radcykowycz, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-24-60	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Blight Inc. 6009 Ha rford Rd. (14)		24a. REC'D BY REGISTRAR MAR 24 '60 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON OFFICE 15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03126

3151

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Manchester</u>				c. LENGTH OF STAY IN 1b <u>10 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Manchester RD #1</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Theodore</u> Middle <u>J</u> Last <u>Myers</u>				4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-19-1882</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min.		IF UNDER 24 HRS. Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Teaching</u>			
11. BIRTHPLACE (State or foreign country) <u>York Co. Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Theodore Myers</u>				14. MOTHER'S MAIDEN NAME <u>Kate Stermer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-14-8937</u>			
17. INFORMANT Address <u>RD #1</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>5 yr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov 48</u> to <u>March 23, 1960</u> that I last saw the deceased alive on <u>Sept 1959</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W H Foard</u>				ADDRESS (Street, city or town, state) <u>Manchester, Md</u>			
PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u>				DATE SIGNED <u>3/23/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3-26-1960</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>St. David's Cemetery Ansoner, Pa.</u>				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dennis R. G. Wetzel</u>				ADDRESS <u>549 Carlisle St. Hanover, Pa.</u>			
24a. READ BY REGISTRAR <u>Mar 29 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>			

MEDICAL CERTIFICATION

1000

CERTIFICATE OF DEATH

3151

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3152 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

03127

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -- Westminster		c. LENGTH OF STAY IN 1b 10 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. D. # 6		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BLANCHE M. REAVER		4. DATE OF DEATH Month March Day 15 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 19, 1889
9. AGE (In years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ephriam Richard Smith		14. MOTHER'S MAIDEN NAME Ida Eyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. 213-38-8060	
17. INFORMANT Mrs. Frank Nelson,		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of bowel 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial degeneration Hemiplegia		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
20a. ACCIDENT WAS UNDERLIEING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1950 to Mar 15, 1960 that I last saw the deceased alive on Mar 5, 1960 and that death occurred at 9 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 Kemper ave Westminster, Md DATE SIGNED 3/16/60			
ACTUAL SIGNATURE Reese Wilkins M.D.		DATE SIGNED 3/16/60	
PHYSICIAN'S NAME (Type) EREESE Wilkins			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-18-1960	
22c. NAME OF CEMETERY OR CREMATORY Morgan Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Carroll Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Maryland	
24a. REC'D BY REGISTRAR DATE MAR 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

4088 • J. Neurosci., September 24, 2008 • 28(39):4082–4091

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NEW YORK, N.Y., May 15, 1964

3153

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Taneytown, Md.				c. LENGTH OF STAY IN 1b 20 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mailing Address Littlestown, Pa. R. D. 1				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle F. Last Revelle				4. DATE OF DEATH Month 3/30/60 Day 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/1877	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Steam Fitter				10b. KIND OF BUSINESS OR INDUSTRY Steam Fitting		11. BIRTHPLACE (State or foreign country) Princess Ann, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Sidney Revelle				14. MOTHER'S MAIDEN NAME Mary Ann Heath			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 579-09-8746		17. INFORMANT Address Carroll Co., Md. Mrs. George F. Revelle, Littlestown, Pa. R. D. 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardio-vascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 2 days 20 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1958 , to March 30, 1960 , that I last saw the deceased alive on March 29, 1960 , and that death occurred at 6:45 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dean M. Little M.D.				ADDRESS (Street, city or town, state) Littlestown, Pa. DATE SIGNED 3/30/60			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/1/60		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hanover, York Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little				ADDRESS Littlestown, Pa.		24a. REC'D BY REGISTRAR DATE APR 1 '60	
				24b. REGISTRAR'S SIGNATURE Charles J. House			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital attending physician. This certificate has been signed by the attending physician and completed by the funeral director. After this page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3154

03129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster 18 yrs.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Westminster Md ROTH 4</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster Md.</u> d. STREET ADDRESS <u>Manchester Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EMORY THOMAS ROBERTSON</u> First Middle Last				4. DATE OF DEATH <u>MARCH 4 1960</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 20 1907</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truckman in Rubber factory</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Harry Thomas Robertson</u>	
14. MOTHER'S MAIDEN NAME <u>Hattie Gertrude Miller</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-05-1278</u>		17. INFORMANT <u>Mrs Emory T. Robertson</u> Address <u>Westminster, Maryland R.D. 4</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James T. Marsh</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>3/4/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/6/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Leisters Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rural, Westminster, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminster, Md.</u>				24. REC'D BY REGISTRAR <u>MAR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0125

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PRESENT RESIDENCE</p> <p>12. DATE OF DEATH</p> <p>13. TIME OF DEATH</p> <p>14. PLACE OF DEATH</p> <p>15. CAUSE OF DEATH</p> <p>16. MANNER OF DEATH</p> <p>17. SIGNATURE OF MEDICAL EXAMINER</p> <p>18. SIGNATURE OF REGISTRAR</p> <p>19. SIGNATURE OF WITNESSES</p> <p>20. SIGNATURE OF CORONER</p> <p>21. SIGNATURE OF JURY</p> <p>22. SIGNATURE OF JUDGE</p> <p>23. SIGNATURE OF CLERK</p> <p>24. SIGNATURE OF SHERIFF</p> <p>25. SIGNATURE OF CONSTABLE</p> <p>26. SIGNATURE OF TOWNSHIP CLERK</p> <p>27. SIGNATURE OF VOTING CLERK</p> <p>28. SIGNATURE OF SCHOOL CLERK</p> <p>29. SIGNATURE OF CHURCH CLERK</p> <p>30. SIGNATURE OF OTHER OFFICIALS</p>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

3155

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1, Film G259. 3/23/60 1b

CERTIFICATE OF DEATH

03130

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>CARROLL Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. <i>Baltimore, Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Uniontown, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cookson Farm Boarding Home, Rt. 5 Westminster, Md.</i>		d. STREET ADDRESS <i>1635 N. Fulton Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		06X-1	
3. NAME OF DECEASED (Type or print) First <i>EMMA</i> Middle <i>K.</i> Last <i>SCOTT</i>		4. DATE OF DEATH Month <i>Mar</i> Day <i>13</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 4 1869</i>
9. AGE (In years last birthday) <i>90</i> yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Francis H. Kohlman</i>		14. MOTHER'S MAIDEN NAME <i>Louisa Kuzmalla</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mr. Charles F. Warthen, 5 W. ...</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio Sclerotic Cardiovascular disease</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Convulsion face at left lip</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>Yes</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Choking on food</i>	
20c. TIME OF INJURY Month, Day, Year <i>11 a.m. Feb 28 1960</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Baltimore, Md.</i>	
21. I certify that I attended the deceased from <i>Sept 28, 1959</i> , to <i>Mar 13, 1960</i> , that I last saw the deceased alive on <i>Mar 12, 1960</i> , and that death occurred at <i>9 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James J. Marsh</i>		DATE SIGNED <i>3-13-60</i>	
PHYSICIAN'S NAME (Type) <i>JAMES J. MARSH</i>		ADDRESS (Street, city or town, state) <i>105 E. ...</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried March 16, 1960</i>		22b. NAME OF CEMETERY OR CREMATORY <i>Landon ...</i>	
22c. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		22d. REC'D BY REGISTRAR <i>DATE MAR 15 '60</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank H. ...</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. ...</i>	

746-4300

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 17

CERTIFICATE OF DEATH

2152

F.D. - Cookson Farm D. H.
Phone 3/16/60
 J.C.L.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
3156
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03131

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>54 yrs. 1 mo. 24 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eakles Mill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Katherine (Kate) Snyder</u>				4. DATE OF DEATH Month Day Year <u>March 21, 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown</u>	
9. AGE (In years lost birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Martin Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Springfield Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease.</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. due to arteriosclerosis with psychotic reaction.</u> INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 7, 1955</u> to <u>March 21, 1960</u> , that (I) (we) last saw the deceased alive on <u>March 21, 1960</u> , and that death occurred at <u>1:10 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Agustin del Campo</u> M.D.				22b. DATE SIGNED <u>3/21/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u>				22d. ADDRESS <u>Springfield Hospital, Sykesville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MARCH 24 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>KEEDYSVILLE MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bost</u>				25a. REC'D BY REGISTRAR <u>Boonsboro MD</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Harris</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03132

3157

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 1yr.6mos.17days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 34014		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 811 E. Baltimore St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roy Middle Earl Last Sprattling				4. DATE OF DEATH Month March Day 2 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1906		9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Luther Sprattling				14. MOTHER'S MAIDEN NAME Elizabeth Cash			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 259-01-7939		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 698X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause last. (b) Large infected pressure sores DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, catatonic type.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 15, 1958 to March 2, 1960 , that (I) (we) last saw the deceased alive on March 2, 1960 , and that death occurred at 1:15PM from the causes and on the date stated above.							
22a. SIGNATURE <i>Edmund Lusthaus</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/2/60	
22c. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-4-60		23c. NAME OF CEMETERY OR CREMATORY Freedom		23d. LOCATION (City, town, or county) (State) Elkridge, Carroll, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Luther H. Wright</i> Sykesville, Md.				25a. REC'D BY REGISTRAR DATE MAR 8 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

04195

ARMY AND NAVY DEPARTMENT OF HEALTH
OFFICE OF THE ASSISTANT SECRETARY
WASHINGTON, D. C.
CERTIFICATE OF DEATH

3157



Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3158 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03133

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Barnell</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u> c. LENGTH OF STAY IN 1b <u>50 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>✓</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Barnell</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>ARTHUR - G - TRACEY</u> First Middle Last				4. DATE OF DEATH <u>Mar 31</u> 19 <u>60</u> Month Day Year											
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 17 - 1888</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Captain</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Burner</u>				11. BIRTHPLACE (State or foreign country) <u>MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>W.C.S.A</u>			
13. FATHER'S NAME <u>E. Clinton Tracey</u>						14. MOTHER'S MAIDEN NAME <u>Rose Hill</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>212-40-4629</u>				17. INFORMANT <u>Mrs A Tracey - Hampstead MD</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon monoxide Poisoning</u> <u>973.3</u> DUE TO (b) <u>Depression</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>2-3 weeks</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>M.C. Porterfield</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <u>3/31/60</u>			
EXAMINER'S NAME (Type) <u>M.C. Porterfield, M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Barnell</u>				22b. DATE THEREOF <u>Apr 3 - 60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Hope</u>				22d. LOCATION (City, town, or county) (State) <u>Balto Co MD</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin Clifton - Hampstead MD</u>						ADDRESS		24a. REC'D BY REGISTRAR <u>APR 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. H. & H. H.</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death and forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
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3159
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03134

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 35yrs.9mos.15days Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mike Middle Zelinsky Last Zelinsky		4. DATE OF DEATH Month March Day 11 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 74 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory work		10b. KIND OF BUSINESS OR INDUSTRY Yunk -	
11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? Alien ✓	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis 002x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type.		INTERVAL BETWEEN ONSET AND DEATH Years
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 7, 19 55 to March 11, 19 60 that (I) (we) last saw the deceased alive on 3/11/60 19 9:40PM , and that death occurred at 9:40PM from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo		22b. DATE SIGNED 3/12/60	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-17-60	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City, town or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haight		25a. REC'D BY REGISTRAR MAR 22 '60	
ADDRESS Sykesville, Md.		25b. REGISTRAR'S SIGNATURE Carlton S. Kneib	

0110

CERTIFICATE OF DEATH

0110

1

Blank certificate form with faint horizontal lines and vertical columns. The form includes fields for personal information, cause of death, and official certification. There are three punch holes on the right side of the page.